The Commonwealth of Massachusetts
Department of Civil Service and Registration
Board of Registration in Medicine
State Office Building, Government Center
100 Cambridge Street, Boston 02202

# ANNUAL REPORT FOR THE FISCAL YEAR 1974

(In compliance with General Laws, Chapter 112, Section 4)

FUNCTION OR PURPOSE: See previous Annual Reports.

MEMBERSHIP: General Laws, Chapter 13, Section 10, as amended by Chapter 1099 Acts of 1973.

G. L. Chapter 13, Section 10 ( as amended by Chapter 1099, Acts of 1973).

There shall be a board of registration in medicine, consisting of seven persons, residents of the commonwealth, six of whom shall be registered as qualified physicians under section two of chapter one hundred and twelve, or corresponding provisions of earlier laws, who shall have been for ten years actually engaged in the practice of their profession, and one of whom shall be a representative of the public, subject to the provisions of section nine B. One member thereof shall annually in June be appointed by the governor, for seven years from July the first following.

9L Chapter 13, Section 9B (c).

If any board shall as a part of its functions delegate any duty or responsibility to be performed by a single member of such board, such delegation shall not be made solely to any public member or any lay member of the board in any of the following instances: 1) the actual preparation of, the administration of, and the grading of examinations 2) the inspection or investigation of licentiates, the manner or method of practice or doing business, or their place of practice or business.

G. L. Chapter 13, 9B (d).

Nothing in this section shall be construed as precluding a public member or a lay member from participating in the formation of policy relating to the scope of the activities set forth in subdivisions (1) and (2) of paragraph (c) of this section or in the approval, disapproval or modification of the action of its individual members, nor preclude such member from participating as a member of a subcommittee consisting of more than one member of the board in the performance of any duty.

G. L. Chapter 13, Section 11. Meetings, Organizations, etc.

A

Said board shall hold regular meetings on the second Tuesdays of March, July and November in each year, and additional meetings at such times and places as it may determine. At the regular meeting in July, it shall organize by the choice of a chairman and secretary, who shall hold their offices for one year. The secretary shall give bond to the state treasurer in the sum of five thousand dollars, with sufficient sureties to be approved by the governor and council, for the faithful performance of his official duties. There shall be paid by the commonwealth to the secretary of the board a salary of fifty-six hundred and twenty-five dollars, to the chairman of the board a salary of twelve hundred and fifty dollars, to each of the other members thereof a salary of one thousand dollars, and to each member thereof his necessary traveling expenses actually incurred in attending the meetings of the board.

MEMBERS OF THE BOARD:

| Name | Date of Original Appointment | Term Expires July 1 |
|---|---|---|
| Joseph M. Baker, M. D.<br>78 Maple Street, Springfield | April 2, 1968 | 1974 |
| Anthony O. Cardullo, M. D.<br>252 Hanover Street, Boston | October 17, 1945 | 1973 |
| Isadore Gross, M. D.<br>89 Wildwood Road, Andover | August 5, 1970 | 1977 |
| Vasilios G. Letsou, M. D.<br>170 Merrimack Street, Lowell | October 10, 1967 | 1978 |
| Stanley M. Slawsby<br>149 Allen Avenue, Waban<br>(replaced Charles W. Sauter, 2nd, D. O.<br>87 South Main Street, Gardner) | July 25, 1972 | 1979 |
| David W. Wallwork, M. D., Secretary<br>5 Third Street, North Andover | February 10, 1955 | 1975 |
| Bancroft C. Wheeler, M. D., Chairman<br>27 Elm Street, Worcester | July 22, 1948 | 1976 |

MEETINGS OF THE BOARD: (General Laws, Chapter 13, Section 11)

Three meetings are obligatory. There were eleven meetings of the Board during the period covered by this report.

ACTIVITIES OF THE BOARD:

Registration of physicians by examination and by endorsement; temporary registration of physicians; limited registration of interns, fellows, residents, medical officers; discipline; complaints; maintenance of records; registration of assistants in medicine; examination, registration, re-registration of physical therapists and registration of physical therapists by endorsement; verification of registration for Registry of Motor Vehicles and for others; approval of hospital affiliations for purposes of training; initiation of legislation; review of proposed new legislation pertaining to registration of physicians and the practice of medicine; establishment of rules and regulations and conduct of hearings pertaining thereto.

LEGISLATION:

The Board often initiates legislation and always reviews and sometimes makes recommendations in regard to proposed new legislation pertaining to registration of physicians and the practice of medicine.

A bill permitting registration of Puerto Rican medical school graduates by endorsement of licensure upon written examination in another state became Chapter 312, Acts of 1973 during the fiscal year of 1973, but was not mentioned in the Annual Report for that year.

In fiscal 1974, the Board submitted five pieces of legislation (four of which were enacted) for the 1973-1974 session.

1. H. 4303, providing registration of American, Canadian and Puerto Rican medical school graduates on the basis of American specialty board certification. Chapter 662, Acts of 1971 had previously provided this avenue of registration for foreign medical school graduates. H. 4303 was incorporated into Senate 1815 which became Chapter 723, Acts of 1974 and is described below.

2. H. 3390, providing increased salaries for board members. This failed to be enacted.

3. H. 3404, a bill to abolish the requirement of a declaration of intentions or a naturalization certificate as a prerequisite for registration as a qualified physician. This was enacted and became Chapter 396, Acts of 1974. Such a requirement had been declared unconstitutional in several states.

4. H. 3405, a bill to abolish the requirement of a declaration of intentions or a naturalization certificate as a prerequisite for registration as a physical therapist. This was enacted as Chapter 290, Acts of 1974.

5. H. 3402, a bill providing simply an editorial change to bring G. L. Chapter 112, Section 2 up to date, deleting reference to Section 209A, Chapter 94 which had been repealed. This change was effected by Senate 1815 which became Chapter 723, Acts of 1974.

Other legislation pertaining to registration and the practice of medicine included:

1. H. 7713 which became Chapter 1060, Acts of 1973, requiring an ECFMG certificate for limited registration of foreign medical graduates after December 31, 1974. This bill was an effort to upgrade medical service in state and municipal hospitals and resulted from close cooperation between the Board and the Belchertown Commission.* It presents a progressive change in medical licensure in the state, but it survived an attempt at repeal in the form of H. 735 only because of continued pressure on the part of the Board and the Belchertown Commission.

2. H. 6237, substituted for Senate 875, a bill to "establish a certain plan to aid students enrolled in accredited medical schools". This became Chapter 444, Acts of 1974 and provides for repayment by the commonwealth of loans to medical students after one, two, three and four years of practice in a city or town, or in case of a city or town having a population exceeding seventy-five thousand, in a section of said city or town as shall be determined by the commissioner of public health to be in need of additional physicians, payment not to exceed $3,000 per academic year.

3. H. 6495, a redraft of four other bills, became Chapter 937, Acts of 1974, establishing a "board of approval and certification of physician assistant programs" in the Department of Public Health. The board is to be made up of two physicians (at least one must be a member of the Massachusetts Medical Society), a representative of an accredited Massachusetts medical school, a representative of a physician assistant training program, an administrator of a health facility, a registered nurse (a member of the Massachusetts Nurses Association), two public members, one physician assistant. A physician assistant is defined as a graduate of an approved program. "A physician assistant may perform medical services when such services are rendered under the supervision of a registered physician. Such supervision shall be continuous but shall not require the personal presence of the supervising physician or physicians. A registered physician shall supervise no more than two physician assistants at any one time. Physician assistants, depending upon their level of professional training and experience as determined by a supervising physician, may perform medical services of a general nature in assisting general practitioners in their own practice, in group practices, or in health care facilities. If a physician assistant is employed by a physician or group of physicians, the assistant shall be supervised by and shall be the legal responsibility of the employing physician or physicians. The legal responsibility of such an assistant shall remain that of the employing physician at all times including occasions when the assistant, under the direction and supervision of the employing physician or physicians, aids in the care and treatment of patients in health care facilities. Such health care facilities shall not be legally responsible for the actions or omissions of the physician assistant. If a physician assistant is employed by a health care facility the legal responsibility for his actions and omissions shall be that of the employing facility. Such physician assistants shall be supervised by registered physicians. Such physician assistants employed by

* Special Commission on Belchertown State School and Monson State Hospital.

health care facilities shall not be utilized as the sole medical personnel in charge of emergency or outpatient services or any other clinical service where a physician is not regularly available".

4. H. 6120 (1973), an act to reorganize and modernize state government by creating a health systems regulation administration in the Executive Office of Human Services, finally became H. 6171. This bill would have made the Board of Registration in Medicine a part of the health systems regulations administration, would have provided a hearing officer for all hearings, with one or more Board members sitting in at each hearing, would have required biennial registration of physicians and continuing medical education as a prerequisite to re-registration, would have provided a "sick doctor" law, would have provided for the administration to handle all complaints, and would have permitted the administrator, with the concurrence of two board members, to suspend any licensee if he found public health or safety in imminent danger, but the licensee suspended would be provided a hearing within three days. The modification of this bill finally left the Board essentially unchanged. It eventually failed of enactment but was referred for state wide referendum on 1974 ballot.

5. S. 668, "an act further regulating the requirement of a degree of doctor of medicine for registration as a physician" substituting in Chapter 112, Section 2, the words "or its equivalent degree" for the words "or its equivalent" failed of enactment this year as it did last year.

6. S. 667 "an act reinstating the requirement of physics, chemistry and biology on a college level for registration as qualified physicians" failed of enactment this year as it did the year before.

7. H. 3410 directed the registration of John Meagher as physical therapist. It failed of enactment.

8. H. 4157 directed the issue of a certificate of registration as a qualified physician to James Christy. It failed of enactment.

9. H. 4153 provided for payment of an annual registration fee of $25 for physicians. It failed of enactment, lost in the legislative-administrative hassle over the bill for the establishment of a health systems regulation administration.

10. H. 6368 established group practice for the faculty of the University of Massachusetts Medical School with reimbursement of the state for services rendered patients in the Massachusetts Teaching Hospital at Worcester and remuneration of the professional staff of each clinical department of the medical school. On August 6, 1974, this became Chapter 733, Acts of 1974. It provides that "every member of the professional staff of each clinical department of the medical school, the majority of whose medical practice consists of rendering patient care at the teaching hospital, whether in-patient or out-patient, shall be a member of the group practice".

11. Senate 1815, sponsored by the Board in cooperation with the Belchertown Commission and the Department of Mental Health, became Chapter 723, Acts of 1974 and involved many changes in Section 2, Chapter 112, G. L. It made registration a straightforward, readily understood and administratively much simpler process. See page 13.

12. H. 6019, amended, became Chapter 421, Acts of 1974, prohibiting experimentation on live human fetuses or upon a dead fetus without the consent of the mother. The Board was not actively involved in the controversy surrounding the enactment of this legislation.

It is obvious that fiscal 1974 was one of unusual legislative activity* so far as the Board and the medical profession were concerned, with a correspondingly increased work load on a staff with more routine matters than it can handle as effectively and promptly as the concerned public has the right to expect.

COMPLAINTS:

Complaints continue to increase in number, including direct letters, referrals from the Consumer Protection Division of the Attorney General's office and from the Executive Office of Human Services. Many of these complaints concern matters not within the Board's jurisdiction. In such cases, the complainant is so notified and, when possible, referred to an agency which might afford help, e.g. the Massachusetts Medical Society, the Massachusetts Osteopathic Association, Blue Cross, Blue Shield, the Departments of Public Health, Public Safety and Mental Health or to the Attorney General's Office. Some are handled by the Secretary by telephone and personal negotiations with the physician concerned. Some complaints could be satisfied only in a court of law and in such instances the Board votes "no action". More routinely, however, the doctor is sent a copy of the complaint and invited to comment thereupon. The full Board considers the complaint and the comments. If it seems necessary or advisable, the doctor is invited to appear before the Board; this happened in three instances. Many complaints are resolved in the course of this process and no further action by the Board is necessary. If this has not occurred, the Board takes appropriate action or none, as circumstances warrant. Sixty-seven complaints received the attention of the full Board. In three instances, fee adjustments resulted. In two instances the complainant was advised that the complaint was not justified - the doctor's position was fully supported. Five cases were referred to the Massachusetts Medical Society. Two were referred to the Department of Public Safety and one of these resulted in a cease and desist order for a dentist practicing acupuncture. One doctor was reprimanded for employment of treatment deemed inappropriate by a committee of his peers (Massachusetts Medical Society).

SIGNIFICANT ACTIONS BY BOARD.

The most significant action by the Board in fiscal 1974 was final approval, filing and publication (October 16, 1973) of Rules and Regulations of the Board for the first time in the Board's history. The necessity for minor changes is already apparent - the field of medicine is not static.

* See pp. 17-20 for more legislative activity pertaining to practice of medicine.

Hospital affiliations are now promptly processed by the Secretary, greatly expediting such approvals. Examinees are now notified of grades obtained in the examinations - these grades previously were not available to the candidates. An increasing number of instances in which interns or residents have been practicing without registration in various hospitals has prompted the Board to adopt a policy of inviting both the doctor and the director of the hospital to appear to explain such delinquency.

The Board voted to support the Executive Office of Consumer Affairs and the Executive Office of Human Services in seeking a contract with the U.S. Department of Health, Education and Welfare, National Center for Health Statistics. The executive offices mentioned would receive approximately $50,000 to hire personnel to work with the boards on a full time basis. For the first year of the contract, these persons would assist the boards in looking at present systems used in the license application process, the license renewal process, and the storage of information. There will be recommendations made as to the needs of the boards for increased clerical personnel to process applications efficiently and to upgrade the present data processing system of the Division of Registration. The contract objective of this upgrading will be to prepare the boards to share information with the National Center for Health Statistics. The new upgraded techniques will also allow the boards to retrieve information in a more rapid fashion, create greater efficiencies in the license application and renewal processes, and make tracking of such projects as continuing education more feasible. The Board of Registration in Medicine sorely needs such assistance.

HEARINGS:

Administrative: These include appearances of physicians before the Board either at the Board's invitation or upon the request of the physician. Appearances in regard to routine initial registration are not included.

1. Twenty-two limited registrations were extended beyond the usual five year limit. Some instances involved appearance of the physician himself; most involved consideration only of a review of circumstances and recommendations by others than the physician himself. Nine such requests were denied.

2. One physician appeared to appeal the Board's refusal to grant endorsement registration on basis of registration in another state after a split FLEX examination taking the best grades in each of two or several examinations to attain a passing grade of 75%. Appeal denied. If a passing grade in the FLEX examination is attained by taking one part at one time and the remainder at another time (as happens with National Boards), registration is granted.

3. Two appearances resulted in registration of physicians who attained in Germany only the designation Arzt and not an actual M.D. degree. Subsequent training and attainment warranted the action taken.

4. Six appearances involved practicing without registration, usually limited registration. In these instances the fault lay with the hospital administrator rather than the physician and both were requested to appear. This represents an apparently recurring and increasing problem. Thus far no disciplinary action has been taken other than compelling the appearance of the hospital administrator.

5. One physician appeared relative to a notice by Federal Drug Enforcement Agency of purchase of excessive amphetamines and cocaine. Action postponed upon receipt of psychiatrist's report, notice of restoration of privileges in hospital, and notice that the BNDD certificate had been restored.

6. One appearance re narcotics violation in California noted on application for endorsement registration resulted in granting registration upon arrangement for appearance before Board every three months until further notice.

7. One applicant requested an appearance claiming that discrimination by the Board prevented his attainment of passing grade with FLEX examination. Represented by his legislator. No action by Board other than review of examination procedure.

8. A physician was asked to appear re cocaine addiction and depression - doctor now "clean" and progressing under psychiatric guidance - has forfeited BNDD and Massachusetts controlled substances certificates- action deferred.

9. Five petitions for restoration were heard - three restorations granted, two denied.

10. One appearance resulted from a complaint that nurses and technicians were signing an allergist's prescriptions - letter of censure.

11. An appearance relative to a narcotics complaint resulted in revocation of a limited registration.

COURT REVERSALS OF BOARD:

1. As reported in last annual report, a candidate was denied registration July 20, 1972 under Category 4, Chapter 662, Acts of 1971 (registration discretionary with Board); denial was reaffirmed October 19, 1972, December 21, 1972, February 15, 1973. The Board was reversed by the court on the basis that an American medical school graduate would have been registered under similar circumstances. Attorney General's representative recommended appeal of the court's decision but the Board declined because of impending legislation which would probably permit registration in any event.

2. A physical therapist had been denied registration as a qualified physical therapist when he failed to take advantage of the grandfather clause in the act establishing registration of physical therapists. The court reversed the Board's decision on the basis of the Soldier's Relief Act, legislation not taken into account by the Board.

ADMINISTRATIVE PROBLEMS:

The Annual Report of 1973 reviewed the improvement in the office administration by a complete change of personnel. This improvement has been sustained. Public relations are now genial and satisfactory. However, problems do remain. Two junior clerks are performing well above their junior clerk status. Their continued junior clerk status, with little hope of advancement, is discouraging and demeaning. The personnel allotted are unable to clear up a backlog of engrossed certificates and unable to process the peak load of limited registration that occurs prior to July 1 each year. Consultations with John Reis, Tabulating Division of Division of Registration, and modification of procedures hopefully will improve the latter situation, but the backlog of certificates can only be whittled down, not promptly completed, without temporary assistance which has not been forthcoming despite repeated protestations. Prompt notification of examinees also has been impossible. The current workload of endorsement registration might be, but has not been, allowed to lag. Possibly public remonstrance would or will be effective. Otherwise, this situation will persist for sometime. Problems with the cash flow remain, as the auditor's report notes, but the deficiencies are related to a heavy workload on underpaid junior clerks and probably will continue.

Net receipts of the Board in fiscal 1974 were $141,906.00. The excess of receipts over disbursements amounted to $79,388.00, the latter amount reverting to the general funds of the commonwealth.

HEARINGS:

Judicial: Six formal hearings were conducted during the period of this report resulting in the following actions by the Board:

1. Guilty - gross misconduct - distribution of controlled substances - drug conviction in court - suspension for six months.

2. Guilty - distribution of controlled substance (desoxyn) not in course of professional practice - probation for six months and surrender of federal and state controlled substances certificates.

3. Guilty - insurance fraud - suspension for six months, execution of suspension indefinitely postponed - criminal action had been severe.

4. Guilty - gross misconduct (assault upon physician) - suspension for 90 days. Appealed in court - Board upheld.

5. Guilty - narcotics for other than therapeutic purposes (addiction) - revoked.

6. Guilty - distribution of controlled substances - surrender of federal and state controlled substances certificate (aged and incapacitated).

In summary there was one revocation, two suspensions, one suspension with postponement of suspension, one probation with surrender of controlled substances certificate, one surrender of controlled substances certificate. As noted under administrative hearings, one limited registration was revoked, three registrations were restored and two petitions for restoration were denied.

## THE MEDICAL PROFESSION IN MASSACHUSETTS IN 1974

(Chapter 112, Section 4. Records; Annual Report. "The Board shall make an annual report, including a statement of the condition of medicine and surgery in the Commonwealth).

The medical profession in Massachusetts, like that in the nation, is in thick soup, alphabet soup - acronym soup - abbreviation soup - whatever one cares to call it. Evidence of this is the following list of some of the designations encountered in the preparations of this report: PSRO, CIM, HMO, CHP, HSAs, CHAMP, HEW, MURA, EMCRO, CPHA, PAS, H-ICDA, ICDA-8, CPT, HUR, POR, LCME, LCGME, ECFMG, FSMB, FLEX, COTRANS, GAP, ABFP, PMP, QAP, MCAT, CMSS, LOS, CPHA, IAMAT, not to mention the old and familiar AMA, AHA, AAMC, NEJM, JCAH, NBME, JAMA, ABMS, NMA. (See page 15 for glossary of acronyms). Then, we have institutes, foundations, support centers, councils, committees, guidelines, pre-admission certificates, concurrent review, prospective review, utilization review, and others, seemingly ad infinitum. In the past year we have had rumors, threats and promises - relicensing, recertification, continuing medical education, federal licensure, indenture of graduating physicians - and these, with all the rest, bid fair to be with us next year and thereafter. One can only be amazed by the multiplicity of organizations and efforts, but at the same time sobered and even distressed by the fact that few, if any, are concerned with the physician's main raison d'etre - the prevention, recognition and treatment of disease in humans. Obviously, the physician of today, to stay alive economically, must devote an amount of effort in other areas than preventing, recognizing and treating human disease that distresses and angers most of them, especially the older members of the profession.* However, all this bureaucracy apparently is here to stay. Most likely the soup will only thicken. Now, a brief review of how we stand in Massachusetts.

It all began with Section 249 F of Public Law 92-603, on October 30, 1972. This law requires that a national network of physician-sponsored and physician-controlled organizations (PSRO's) be formed to review care, provided in institutions, that is paid for by the Medicare, Medicaid or Maternal and Child Health Programs. The PSRO must determine whether the care was necessary, was of acceptable quality and was delivered in the most economical setting. The A. M. A. backed and filled, split and united, but, with the support of the Massachusetts delegation,** finally adopted a pledge to work for constructive changes rather than repeal, in an attempt to make the system work for quality care and cost-effectiveness. Meanwhile, HEW beat the June 30, 1974 deadline for commitment of fiscal 1974 funds by awarding contracts to eleven conditional PSRO's (two in Massachusetts);

* See p. 14 "Medicine's Uncomfortable Role".
** See p. 14a, Dr. Ballantine's remarks.

and ninety-nine (99) planning organizations (eleven in Massachusetts); and thirteen (13) Support Centers (one in Massachusetts). The award to one of the foundations in Massachusetts (Bay State) was the largest conditional contract awarded. "Clearly, the state enters the first year of the operational PSRO program as somewhat of a national PSRO model (1)". The awards were:

Commonwealth Institute of Medicine for establishment of the Support Center ---------- $289,412

Charles River Health Care Foundation, Inc. (Area III) for an 18 months conditional contract ---------- $503,420

Bay State Foundation for Medical Care, Inc. (Area IV) for an 18 months conditional contract ---------- $3,206,680

Health Care Foundation of Western Mass. Inc. (Area I) for a six months planning contract ---------- $46,150

Central Massachusetts Health Care Foundation, Inc. (Area II) for a six months planning contract ---------- $64,000

Pilgrim Foundation for Medical Care, Inc. (Area V), for a six months planning contract ---------- $61,000

$4,171,162 and not one penny of this for actual medical service! It is hoped that one can be forgiven if he has some misgivings about the cost effectiveness of such a program, but this sum must be considered against a background of total Medicaid and Medicare expenditures in Massachusetts of more than $800,000,000.

The Commonwealth Institute of Medicine, with funds from HEW, will manifest its support center function by establishing the nation's first training academy for PSRO personnel, a program designed to be a prototype for the entire country. Curricula will be developed for training Medical Care Coordinators (presently known in the Bay State as CHAMP coordinators). Academy graduates then would qualify to coordinate concurrent medical audit/utilization review programs for hospitals and PSRO's. In addition the academy will develop curricula for administrators and physicians as part of an overall plan to educate health personnel and facilitate implementation of PSRO requirements.

The older conservative physician with misgivings about four million dollars' worth of clerical work can take some solace from another 1974 happening, however. The University of Massachusetts Medical School graduated its first class - sixteen physician neophytes! Dean Lamar Soutter, with indomitable courage, with tireless perseverance and patience, has thus accomplished the charge given him by the Governor and the Great and General Court of the Commonwealth - a monumental task assigned to and completed by a monumental physician. We wonder whether he shares the pessimism of Dr. C. H. Plimpton (President, Down State Medical Center, N.Y.) in his oration before the graduating class in assigning physicians

(1) PSRO Update, B. U. Medical Center, No. 4, July 1974

to the third social tier in the future "Pyramid of Society". Were all physicians of Lamar Soutter's stature, this certainly could not occur.

Throughout the year, Governor Sargent's administration has been working heroically to formulate legislation reorganizing the Department of Public Health and the various Boards into a Health Systems Regulations Administration under the Executive Office of Human Services. Under severe pressure from the various Boards, particularly the Board of Nursing, many of the less wise provisions of the original bill were modified until it became a bill which the Board of Medicine could accept. Actually, in the final version, the Board of Medicine's functions remained practically unaltered, but even the final version involved biennial registration (which is probably inevitable) and continuing medical education as a prerequisite for re-registration (an administrative nightmare). This bill eventually failed of enactment, but will be the subject of a statewide referendum in October.

Much more menacing is Senator Kennedy's S. 3585,* "A bill to amend the Public Health Service Act to revise and extend the programs of assistance under title VII for training in the health and allied health professions, to revise the National Health Service Corps program, and the National Health Service Corps scholarship training program, and for other purposes". This bill provides federal licensure, relicensure every six years, recertification for relicensure, indentured service in the National Health Service Corps for every medical school graduate for two years in areas where care is lacking, enforced by withholding capitation grants from medical schools if all students do not sign up for such indentured service, and limits the number of foreign medical school graduates allowed to practice in U. S. by limiting internships and residencies to 110% of the number of U. S. graduates. Furthermore, decisions on how many doctors are to be allowed to practice where and in what specialties will, according to S. 3585, come under the authority of a "National Council of Postgraduate Physician Training". The council would "determine the desired balance of physicians in the various medical and surgical specialties and subspecialties". In other words, physicians would be regimented more severely than any other segment of the population. Portions of this bill possibly would be ruled unconstitutional, but in any event, considering the wide acceptance (all states except Texas) of FLEX as a licensing examination, the proliferating programs for continued medical education, the imminence of national health insurance, this bill is unnecessary, highly undesirable, unduly expensive, and denigrating to physicians. In many ways it will lessen the number of physicians providing health care and thus defeat its primary purpose. It is a proposal that is entirely out of proportion and goes far beyond what is needed.

This annual report could scarcely be complete without mention of the Report of the Committee on Goals and Priorities (GAP) of the National Board of Medical Examiners (of which the Secretary of the Board is a member), "Evaluation of the Continuum of Medical Education". Briefly, this report concluded that the medical school graduate is not qualified for the unsupervised practice of medicine, that each such graduate should be qualified by examination (the same examination for American and foreign medical school graduates) for the supervised practice of medicine and should have either board certification or a passing grade

* failed of enactment October, 1974!

in a second examination after two years of supervised practice before being admitted to the unsupervised practice of medicine, i. e. being licensed. This second recommendation was based on the fact that nearly 90% of American graduates do now in fact seek board certification and probably will continue to do so.

These recommendations would indicate certain changes in Massachusetts licensing procedures. Limited registration would be granted on the basis of successful completion of Qualifying A rather than simply two years of premedical and three and a half years medical education. Licensure on the basis of FLEX after graduation from medical school would no longer be available - full licensure would require at least two years of supervised training after the granting of the M. D. degree. Massachusetts already licenses by endorsement of board certification. The report recommends also a cooperative effort by all agencies involved in medical education to provide a rational, effective program of continuing medical education for physicians with provisions for monitoring and assessing such education. "This report represents the views of the Committee on Goals and Priorities and its best judgment of the steps necessary to improve and enhance the evaluation system in medicine in the United States". " A multitude of voluntary, governmental, professional and quasi-legal agencies have been developed to accredit institutions and programs to certify individual competence at various educational levels and to grant licenses to practice. The evaluation procedures are supervised by a large number of rather uncoordinated agencies. Yet no formal mechanism exists to modify the system in order to respond to changing manpower needs". Interestingly, this report outlines a voluntary mechanism for doing what Senator Kennedy's S. 3585 would attempt to do by legislative fiat with little recognition of the difficulties involved or recognition of the present efforts of the profession itself to slowly evolve an effective program.

Licensure in Massachusetts in 1974 underwent highly significant changes in the enactment of Senate 1815, Chapter 723, Acts of 1974 as noted on page 6 and the failure of H. 735 to repeal Chapter 1060, Acts of 1973. After December 31, 1974, the FMG without ECFMG certification will be ineligible for limited registration. The so-called "FMG underground" should no longer exist in Massachusetts. Furthermore, limited registration for any physician can be enjoyed only for five years, after which the candidate must qualify for full registration or withdraw from medical practice in Massachusetts. This will result in significant upgrading of medical service in state hospitals, the major objective of the legislation. FMGs will be licensed by endorsement in the same manner as graduates of American schools. American and FMGs will be licensed by endorsement of board certification. No doctor will be licensed simply on the basis of ten years of service in the Armed Forces or the Public Health Service.

One remaining problem in licensure is presented chiefly by graduates of the medical schools in Bologna and Guadalajara, where the degree of doctor of medicine is not granted unless the candidate serves at least one year of a kind of social service. Such candidates now enter American medicine by the A. M. A. "Fifth Pathway" (sponsorship by an American medical school in an approved clinical clerkship qualifying the candidate for admission to an approved internship or residency program) and their licensure in Massachusetts is governed thus far not by legislation but by rules and regulations of the Board.

Licensure by examination in Massachusetts has been limited recently almost 100% to FMG's and the failure rate has been high, 40% to 50%, in some degree reflecting repeated attempts by individuals with little hope of success, but nevertheless quite in line with the national average performance of FMG's on this examination. In the December 1973 examination, the Massachusetts failure rate was 39.8%. The National failure rate 40.9%. The performance of U. S. and Canadian medical school graduates in the December 1973 examination revealed failure rates of 8.7% to 77.5%, depending upon the number of years since graduation. This relationship for all candidates was:

| Years after M. D. | % Fail |
|---|---|
| 0 | 9.9 |
| 1-5 | 32.0 |
| 6-10 | 44.6 |
| 11 plus | 64.9 |

An argument for proponents of continuing medical education as a requisite for relicensure?

In the calendar year of 1973, 36,462 licenses were issued in the U.S., 1099 in Massachusetts. Of the 36,462 in the nations, 16,689 represented new additions to the medical profession, 490 of them in Massachusetts. Of these last, 145 or 30% were FMG's. The national percentage was 44%.

In summary, it would appear reasonable to conclude from a public point of view that the legislature and the administration have been alert, alive, aware, and active so far as the medical profession is concerned and that both the Board of Registration and the profession as a whole have lived up to and discharged their obligations in a responsible and commendable manner.

MEDICINE'S UNCOMFORTABLE ROLE.

Benjamin B. Okel, M. D., president, DeKalb County, Georgia, Medical Society, in his inaugural address:

I, like most physicians, find the practice of medicine to be increasingly frustrating. We are all thrown into roles we don't like to play. The medical profession today finds itself in a similarly uncomfortable position to that of the clergy in the Renaissance and at the time of the Reformation. In past centuries the priest represented the most important force in the world - the sacred power of God which promised a happier life beyond. Americans today, at least by comparison with past generations, have no firm belief in afterlife. Rather they believe in a heaven on earth through personal identity, human relationships, fame, entertainment and various forms of self-in-dulgence.

Health is most assuredly necessary to enjoy this worldly heaven. Thus the physician becomes a modern day priest. The impossibility of the task assigned our medical priesthood is painfully apparent. When our profession is found wanting

in this imposed role as the new priesthood, an antimedical movement develops. The financial demands of the medical profession become an outrage just as the financial demands of the clerics in earlier times caused similar hostility. We all feel the frustrations of this unsought role and face more dilemmas now than ever before. The doctor of medicine has always walked a tightrope between undertreatment and overtreatment, between underinvestigation and overinvestigation. He now daily faces situations where it's be-damned if you do, be-damned if you don't. He must cope with third party involvement. Patients no longer have incentives to economize. At the same time physicians receive primary blame for soaring health costs. We are blamed for and are expected to cure problems which are basically social in cause. This analogy between health and heaven is particularly pertinent to the political scene today. Any politician who promises to his electorate health or "the right to health" is practically promising Paradise. Considerable courage is required for a congressman or senator to oppose creation of a medical system that guarantees a heaven on earth - particularly if it is billed as being free.

I often feel that physicians today have little more to do with assuring health than a priest in the 16th century had to do with assuring his parishioners a place in heaven.....

American Medical News - August 26, 1974.

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OUTLINE OF REASONING OF ONE MASSACHUSETTS DELEGATE.

There are six other sections in the original Medicare-Medicaid Law which give the Secretary of HEW the mandate and the power to be certain that expenditures for items and services under Titles XVIII and XIX (Medicare and Medicaid) are medically necessary. They provide for audit, for an inspection of records; they provide for penalties if the Secretary of HEW finds that medical services have been provided which he believes to be unnecessary or "of grossly inferior quality", and all of this under a bureaucratically dominated hierarchy of carriers, intermediaries, consumer representatives and bureaucrats within HEW. The Federal and State Governments have had the power since 1965 to do all of the things mandated under the PSRO law, and they do not have to go to the physicians for advice. PSRO, then is an attempt to put back into the hands of the physicians the peer review process, and to me the great tragedy of the PSRO controversy is that almost no physician seems to be aware of the power of the Federal Government that already exists, uncontrolled and unlimited, without PSRO and that PSRO is an attempt to limit these powers by putting decision making into the hands of people like yourselves. This, I feel, calls into question the leadership of the A. M. A. I truly believe that had the physicians of America understood the alternative to PSRO, which is to leave medical determinations in the hands of the bureaucrats, this controversy would never have started.

H. Thomas Ballantine, M. D., Council, Massachusetts Medical Society,
June 3, 1974

REVIEW OF WORK LOAD - BOARD OF REGISTRATION IN MEDICINE

1943-1974 (31 years)

| YEAR | Total Full Registration | Registration by National Boards. | Registration by Endorsement License in another State. | Registration by Exam. | Registration of Foreign Medical School Graduates | Graduates of Unapproved Medical Schools | Limited Registrations | Registration of Medical Assistants | Verification for Registry of Motor Vehicles |
|---|---|---|---|---|---|---|---|---|---|
| 1943 | 131 | 47 | 0 | 88 | 2 | | 255 | 255 | |
| 1944 | 352 | 105 | 0 | 247 | 15 | 142 | 373 | 395 | |
| 1945 | 229 | 88 | 0 | 141 | 11 | 52 | 509 | 385 | |
| 1946 | 395 | 283 | 0 | 112 | 8 | 28 | 569 | 414 | |
| 1947 | 563 | 367 | 113 | 83 | 7 | 26 | 445 | 112 | |
| 1948 | 427 | 248 | 101 | 78 | 5 | 38 | 571 | 345 | |
| 1949 | 390 | 276 | 53 | 61 | 13 | 24 | 701 | 280 | |
| 1950 | 380 | 280 | 62 | 38 | 11 | 11 | 778 | 289 | |
| 1951 | 234 | 153 | 57 | 24 | 5 | 7 | 706 | 305 | |
| 1952 | 379 | 271 | 73 | 35 | 9 | 5 | 774 | 305 | |
| 1953 | 369 | 266 | 64 | 39 | 10 | 4 | 928 | 325 | |
| 1954 | 409 | 295 | 76 | 38 | 10 | 3 | 1283 | 331 | |
| 1955 | 411 | 298 | 72 | 41 | 11 | 3 | 1707 | 314 | |
| 1956 | 378 | 278 | 69 | 31 | 14 | 0 | 1729 | 296 | |
| 1957 | 349 | 248 | 65 | 36 | 24 | 0 | 2037 | 313 | |
| 1958 | 401 | 265 | 100 | 36 | 23 | 1 | 2158 | 314 | |
| 1959 | 432 | 394 | 81 | 47 | 34 | 0 | 2231 | 325 | |
| 1960 | 431 | 289 | 98 | 44 | 21 | 0 | 2207 | 325 | |
| 1961 | 441 | 282 | 118 | 41 | 34 | 0 | 2238 | 310 | |
| 1962 | 421 | 274 | 102 | 45 | 34 | 0 | 2008 | 310 | |
| 1963 | 503 | 362 | 102 | 39 | 33 | 0 | 2244 | 301 | |
| 1964 | 507 | 358 | 108 | 41 | 33 | 0 | 2118 | 304 | |
| 1965 | 580 | 430 | 147 | 43 | 37 | 0 | 2012 | 254 | |
| 1966 | 570 | 393 | 134 | 44 | 46 | 0 | 2506 | 335 | 3948 |
| 1967 | 698 | 465 | 141 | 92 | 86 | 1 | 2318 | 304 | 365 |
| 1968 | 708 | 482 | 156 | 70 | 65 | 0 | 2442 | 303 | 206 |
| 1969 | 794 | 547 | 164 | 83 | 78 | 0 | 2504 | 414 | 166 |
| 1970 | 805 | 577 | 175 | 53 | 51 | 0 | 2450 | 459 | 123 |
| 1971 | 950 | 616 | 176 | 104 | 101 | 0 | 2647 | 500 | 95 |
| 1972 | 1094 | 681 | 230 | 143 | 135 | 0 | 2900 | 446 | 105 |
| 1973 | 1152 | 697 | 253 | 144 | 132 | 0 | 2058 | 402 | 82 |
| 1974 | 1155 | 749 | 288 | 118 | | 0 | 2138 | 730 | 350 |

OVER for statistics re Physical Therapists.

| Physical Therapy Registration | | | | |
|---|---|---|---|---|
| Year | Renewals | Examination | Waiver | Endorsement |
| '53 | | | 338 | |
| '54 | | | 123 | |
| '55 | | | 3 | |
| '56 | | | 71 | |
| '57 | | 29 | 2 | |
| '58 | | 1 | 0 | |
| '59 | | 34 | 0 | |
| '60 | | 67 | 174 | 1 |
| '61 | | 43 | 0 | |
| '62 | | 67 | 0 | |
| '63 | | 57 | 0 | |
| '64 | | 47 | 0 | 7 |
| '65 | | 59 | 0 | 1 |
| '66 | | 65 | 0 | |
| '67 | | 51 | 0 | 3 |
| '68 | 1019 | 60 | 0 | 2 |
| '69 | 18 | 77 | 0 | 3 |
| '70 | 1209 | 91 | 0 | 4 |
| '71 | 60 | 98 | | 27 |
| '72 | 1422 | 72 | | 40 |
| '73 | 35 | 120 | 0 | 73 |
| '74 | 1559 | 180 | 0 | |
| | | | | |

| YEAR | INCOME | EXPENDITURES | INCOME REVERTED TO GENERAL FUND |
|---|---|---|---|
| 1952 | $16,571.25 | $17,258.87 | $ -687.62 |
| 1953 | $16,851.00 | $17,451.88 | $ -600.88 |
| 1954 | $19,886.55 | $18,084.59 | $ 1,801.96 |
| 1955 | $29,898.25 | $20,889.84 | $ 9,008.41 |
| 1956 | $29,176.00 | $23,670.06 | $ 5,505.94 |
| 1957 | $30,330.00 | $24,824.11 | $ 5,505.84 |
| 1958 | $35,070.00 | $24,430.99 | $10,639.01 |
| 1959 | $36,082.25 | $24,519.21 | $10,563.04 |
| 1960 | $48,725.00 | $25,738.40 | $22,986.60 |
| 1961 | $46,318.00 | $27,133.86 | $19,184.14 |
| 1962 | $50,208.10 | $29,187.10 | $21,021.00 |
| 1963 | $50,636.33 | $29,965.68 | $20,670.65 |
| 1964 | $55,853.10 | $29,338.75 | $26,514.35 |
| 1965 | $64,298.00 | $32,518.54 | $31,779.46 |
| 1966 | $70,581.00 | $37,751.37 | $32,829.63 |
| 1967 | $71,816.10 | $39,250.07 | $32,566.03 |
| 1968 | $78,629.46 | $38,265.46 | $30,364.00 |
| 1969 | $78,473.11 | $36,146.61 | $42,326.50 |
| 1970 | $103,821.18 | $45,983.49 | $58,446.78 |
| 1971 | $106,793.40 | $49,469.10 | $57,324.30 |
| 1972 | $136,309.88 | $47,739.02 | $88,570.86 |
| 1973 | $123,533.28 | $44,170.05 | $79,363.23 |
| 1974 | $141,906.00 | $62,518.00 | $79,388.00 |

## LIST OF DESIGNATIONS

| | |
|---|---|
| PSRO | Professional Standards Review Organizations (Section 249 F, Public Law 92-603). |
| CIM | Commonwealth Institute of Medicine. |
| HMO | Health Maintenance Organization. |
| CHP | Comprehensive Health Planning. |
| HSAs | Health Systems Agencies. |
| CHAMP | Commonwealth Hospital Admissions Monitoring Program. |
| HEW | Department of Health, Education and Welfare. |
| MURA | Massachusetts Utilization Review Associates - formally organized utilization review personnel. |
| EMCRO | Experimental Medical Care Review Organizations. |
| CPHA | Commission on Professional and Hospital Activity. |
| PAS | Professional Activity Study. |
| H-ICDA | Hospital International Classification of Diseases, Adapted. |
| ICDA-8 | International Classification of Diseases, Adapted, recent revision. |
| CPT | Current Procedural Terminology. |
| HUR | Hospital Utilization Review Committee. |
| POR | Problem Oriented Record. |
| LCME | Liaison Committee on Medical Education. |
| LCGME | Liaison Committee on Graduate Medical Education. |
| ECFMG | Educational Council for Foreign Medical Graduates - recently fused with Commission on Foreign Medical Graduates to form Educational Commission for Foreign Medical Graduates. |
| FSMB | Federation of State Medical Boards, Inc. |
| FLEX | Federation Licensing Examination. |
| COTRANS | Coordinated Transfer Application System - for foreign medical students transferring to American medical schools. |
| GAP | Report to National Board of Medical Examiners of its Committee on Goals and Priorities. |
| ABFP | American Board of Family Practice. |
| PMP | Patient Management Problems. |
| QAP | Quality Assurance Program. |
| MCAT | Medical College Admission Test. |
| CMSS | Council of Medical Specialty Societies. |
| LOS | Length of Stay. |
| CPHA | Commission on Professional and Hospital Activities, 1959. |
| IAMAT | International Association for Medical Assistance to Travellers. |
| AMA | American Medical Association. |
| AHA | American Hospital Association. |
| AAMC | Association American Medical Colleges. |
| NEJM | New England Journal of Medicine. |
| JCAH | Joint Commission on Accreditation of Hospitals. |
| NBME | National Board of Medical Examiners. |
| JAMA | Journal of the American Medical Association. |
| ABMS | American Board of Medical Specialties. |
| NMA | National Medical Association. |

PROMPT PAYMENT OF BENEFITS
(Chapter 74, Acts of 1974)
[Effective June 30, 1974[ Chapter 732 .

This Act amends M.G.L. Chapter 176 A and 176 B by establishing a specific procedure to provide prompt payment of benefits to subscribers by hospital service corporations and medical service corporations.

The Act requires that within 15 days of notice by a subscriber that services have been rendered for which the subscriber is entitled to direct payment under a contract, the 176 A or 176 B Corporation must furnish the subscriber with proper forms to establish his entitlement. Within 45 days of receiving completed forms the Corporation will:

1. Make prompt payment
2. Notify subscriber in writing stating reasons for non-payment
3. Notify subscriber in writing of additional information or documentation necessary to establish such benefits

COMMENT: Last minute amendments in Ways and Means Committee removed language that would have inserted such requirements into existing subscriber contracts on grounds that the State cannot modify or change existing contracts by post-contract statute

DISPENSING OF CONTROLLED SUBSTANCES
(Chapter 326, Acts of 1974)
[Effective September 8, 1974]

No person may dispense a controlled substance or any substance intended for hypodermic use unless said person is:

1. A registered pharmacist
2. An assistant pharmacist who is acting in the course of his employment in a pharmacy
3. An intern in pharmacy under the direct supervision of a registered pharmacist (subject to the regulations of the Board)
4. A practitioner as defined in Chapter 94 C, M.G.L.A.

Clerical or ministerial supportive services not requiring professional judgment may be performed by an individual under the direction and supervision of a registered pharmacist. The Board of Registration in Pharmacy will make necessary rules and regulations to define supportive services which can be performed. The registered pharmacist is responsible for the action of any supportive personnel under his supervision.

COMMENT: Regulations further defining this Chapter are now in the preparation stage by the Board of Registration in Pharmacy. MHA, along with the Massachustts Society of Hospital Pharmacists is preparing presentation and comment on the proposed regulations.

INTOXICATION BLOOD TEST
(Chapter 425, Acts of 1974)
[Effective September 25, 1974]

Allows a registered nurse as well as a physician to take blood for chemical tests and analyses designed to measure whether a person is operating a motor vehicle while under the influence of intoxicating liquor.

ABORTION PROCEDURES INCLUDING CONSENT REQUIREMENTS
(Chapter 706, Acts of 1974)
[Effective October 31, 1974]

Proscribes abortions after 24 weeks unless necessary to save life of mother or if continued pregnancy will impose substantial risk to physical or mental health of mother.

Also requires:

1. During or after 13th week procedure may only be performed in a hospital with facilities for general surgery.
2. During or after 24th week procedure can only be performed in hospital with obstetrical services
3. Consent of parents for unmarried mother under 18 years of age.

COMMENT: A more detailed analysis of this Act has been forwarded to chief executive officers of member hospitals. (See Advisory #128)

CRIMINAL RECORD OF EMPLOYEE--UNLAWFUL DISCRIMINATION
(Chapter 531, Acts of 1974)
[Effective October 10, 1974]

It will be unlawful for an employer, in any manner relating to employment of an individual, to request information, keep records or discriminate against a person for failure to provide information, either written or oral, regarding:

1. An arrest, detention or disposition regarding any violation of law in which no conviction resulted.
2. A first conviction of drunkenness, simple assault, speeding, minor traffic violation, affray or disturbance of the peace.
3. Any conviction of a misdemeanor when the date of such conviction occurs 5 or more years prior to application for employment, unless such person has been convicted of any offense within 5 years immediately preceeding the date of application for employment.

No person shall be held to be guilty of perjury by reason of his failure to provide such information.

REPORTING OF BURN INJURIES
(Chapter 122, Acts of 1974)
[Effective April 19, 1974]

This will require those individuals professionally authorized to examine or treat a person with burn injuries affecting five percent (5%) or more of the surface area of the body to report such injury to the Department of Public Health within 14 days. Prior to passage of this Act reporting was necessary only when it was believed the injury resulted from fabric ignition. Reporting forms will be issued by the Commonwealth subject to the rules and regulations of the Department of Public Health.

This Act contained an emergency preamble and became effective April 19,1974.

REQUIRE MEDICAL TESTS OF IMMUNITY TO RUBELLA FOR WOMEN SEEKING CERTIFICATE OF MARRIAGE.
(Chapter 134, Acts of 1974)
[Effective July 18, 1974]

This Act places additional requirements on the physician prior to issuance of a certificate of marriage to a woman. They are as follows:

1. That the woman has been tested and found immune to rubella infection.
2. If not immune, she must be advised of the risks of contracting rubella during childbearing years and of the availability of an immunizing vaccine and of the risks involved in such immunization should the possibility of pregnancy exist or should she become pregnant within 4 months of vaccination and has been advised of the advisability of receiving a pregnancy test.
3. If not tested, she must be offered a test to accomplish point one and two above.

Test requirement would not apply if physician certifies that the woman is past childbearing age or incapable of conception.

FILLING OF PRESCRIPTIONS
(Chapter 264, Acts of 1974)
[Effective August 26, 1974]

Retains provision of existing law which states that no prescription in Schedule II or III may be filled for more that 30 day supply upon any single filling, but adds the following exception, dextro amphetamine sulphate and methyl phenidate hydrochloride if used for the treatment of minimal brain dysfunction or narcolepsy may be filled for up to 60 days supply upon a single filling.